Healthpoint

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FINANCING GRADUATE MEDICAL EDUCATION IN MASSACHUSETTS

Graduate medical education (GME) is a multi-billion dollar enterprise that provides a valuable product — trained physicians — to the nation. In 1996, the Congressional Budget Office estimated the costs of GME at over $6.7 billion dollars. Massachusetts hospitals' direct costs of training medical residents exceed $300 million per year. Recent developments in the health care system — discussions about savings in the Medicare program, competitive pressures brought by managed care and public policy changes — threaten the financing of GME in Massachusetts and throughout the nation. At the same time, there are calls to reduce the overall number of residents nationwide and to emphasize the training of primary care residents. This issue of *Healthpoint* examines policy implications concerning graduate medical education financing and what is at stake for institutions in Massachusetts.

Current Funding Sources

Graduate medical education involves the financing of physician residency, nursing and medical student training. This discussion will focus only on physician residency which comprises the bulk of GME expenditure. Graduate medical education is funded through various mechanisms. The largest source by far has been the federal Medicare program. Medicare reimburses health care institutions, mainly teaching hospitals but increasingly managed care organizations, for GME with an allowance built into its inpatient hospital payments. There is a direct payment for costs such as salaries and an indirect adjustment for associated costs of physician training. Massachusetts hospitals received $342 million for GME from Medicare in 1993 (most recent data available).

State funds, amounting to about $20 million per year, support GME via the Medicaid program, which includes an allowance for direct medical education costs only in its payments to hospitals. Teaching hospitals finance GME costs through charges to their privately insured patients. There are also research grants to which teaching hospitals have access; Massachusetts hospitals receive the highest share of National Institutes of Health (NIH) grant funds of any state in the nation.

GME as a "Public Good"

The financing of GME is justifiably broad-based, because graduate medical education is a "public good." It provides large volume physician services in teaching hospi-

Direct Spending for GME by Massachusetts Acute Hospitals
Fiscal Year 1996

Hospital	GME Costs ($ millions)	FTE Residents*
Brigham and Women's	$ 51.4	551
MGH	$ 48.5	544
Baystate	$ 31.2	234
Boston City[1]	$ 26.9	227
Cambridge	$ 18.8	39
Children's	$ 17.0	446
UMMC	$ 15.6	271
Deaconess[2]	$ 15.2	162
NEMC	$ 15.2	334
BUMC	$ 12.5	152
All hospitals	*$ 336.5*	*4241*

*Full time equivalent intern, resident and fellow positions reported by hospital

[1]Merged with BUMC
[2]Merged with Beth Israel ($8.0m, 288 FTE)

Source: DHCFP-403

Table 1

tals which often disproportionately bear the burden of providing care for the indigent. Five teaching hospitals participating in GME in Massachusetts — Boston Medical Center, Cambridge Hospital, Brigham & Women's, Massachusetts General and Bay State Medical Center — provide the lion's share of uncompensated care to the uninsured and underinsured in Massachusetts. GME payments to teaching hospitals also help to maintain the availability of high quality specialty care, such as endocrinology, neurosurgery, cardiac surgery and orthopedic surgery, for state residents.

GME funding provides for the training of most future clinicians for whom residency is the bridge to a clinical career. Also, residents and fellows often conduct medical research funded by GME dollars. This research sometimes results in path-breaking mechanisms of prevention, treatment and management of disease. These social benefits to which GME contributes warrant broad sharing of GME costs, rather than assigning those costs to a single, narrow source, whether public or private.

The Changing Demographics of Residents

Trends in the physician workforce invite policy action that might include reduced GME funding for certain residents. In February, the American Medical Association, the Association of American Medical Colleges, other professional and academic medical associations issued the *Consensus Statement on the Physician Workforce,* which identified an oversupply of physicians overall, with a shortage in some geographic areas and specialties. There is currently a growing need for more primary care and family practice physicians in this managed care era. The Massachusetts Medicaid program recognizes this by reimbursing hospitals more for primary care residencies than for specialties.

Massachusetts has the second highest ratio of physicians to population in the country. In addition, the state is among the top 10 states in the number of international medical graduates (IMGs) in its residency programs. Many IMGs fill a need during their residencies by providing care in underserved areas, a major element of teaching hospitals' public mission. But the general surplus of physicians and the pressure to reduce Medicare spending put IMGs in jeopardy because financing the residencies of foreign medical school graduates, who may specialize further or not stay to practice in the community, can be seen as less in keeping with long-term state healthcare workforce needs. Massachusetts hospitals are therefore vulnerable to cuts in funding for IMGs. As this debate proceeds, however, it should be noted that fully 44 percent of IMGs nationally are US citizens or permanent residents.

Policy Challenges for Financing GME

A number of factors in the health care environment pose threats to the current system of financing medical education. One challenge lies with federal GME financing. Current proposals suggest cuts of over $100 billion in proposed Medicare spending by 2000, which would create a significant gap in GME funding.

Other challenges lie within teaching hospitals. Hospital admissions, patient revenues and research dollars are slowing or declining. Teaching hospitals are being asked to look for alternative and innovative ways to finance their teaching responsibilities in a health care environment that is demanding that residents be trained in primary care settings where the dollars are sparse. Private payers, under pressure to control *their* costs, are shifting their business to less expensive sites of care since teaching hospital costs are typically higher than those of non-teaching hospitals. These shifts make fewer resources available for GME at the hospital level. The research grant pool is also diminishing relative to research costs.

Managed Care and GME

Finally, a challenge lies with managed care organizations (MCOs), both as a source of funds and a source for care. Managed care currently accounts for over 50 percent of private group health insurance in Massachusetts. As payers, MCOs, with their market strength and reputation for cost control, exert downward pressure on hospital revenues which, for teaching hospitals, include funds used for GME.

Managed care plans have also entered the competition for receiving Medicare payments as they enroll Medicare clients in senior HMOs. These payments — a fixed fee per member — are calculated as a percentage of the average fee-for-service Medicare payment in an area, and implicitly include the proportion for residency training and services that is part of Medicare rates. The question of whether this portion of Medicare dollars actually gets into the GME funding stream — either in the form of payments to hospitals or through the direct training of physicians — is a subject of debate. Fewer than 15 percent of HMOs nationwide participate directly in graduate medical education.

Some MCOs in Massachusetts are experimenting with putting a medical school department within the confines of their MCO sites. Such a model has been promoted as potentially able to transform academic medicine from being clinically based to being more community oriented, with an emphasis on training primary care physicians. The question remains whether this will be a more cost-effective way to train residents, whether the quality of resident training will be upheld or improved, and whether ambulatory care sites that are being asked to train residents will become overburdened.

Current Policy Proposals

Because of its wide social benefits, there is general agreement that all stakeholders — teaching and non-teaching hospitals, private insurers, employers and government — should share in the social cost of graduate medical education. Cuts in GME funding from the federal government seem inevitable; public dollars will still be needed to support GME since private sector dollars alone will be unable to sustain it.

The idea of a trust fund, where a common pool of resources independent of the reimbursement for care is garnered from hospitals and insurers, has been a constant feature of recent proposals. The Institute of Medicine supports the replacement of the current Medicare funding of GME with a Na-

Residents and IMGs by State
1995

State	Residents	Residents per 100,000 population	IMGs as % of of total residents*
NY	14,937	83	44%
CA	8,678	29	12%
PA	6,585	55	23%
TX	6,032	36	17%
IL	5,415	47	35%
OH	4,763	44	21%
MA	*4,345*	*72*	*21%*
FL	2,617	20	19%
DC	1,693	279	20%

*Data are for 1993-94

Sources: JAMA September 6, 1995, Vol. 274, No.9; AAMC Data Book, Table F-11,12

Table 2

tional Graduate Medical Education Trust Fund. Other suggested non-Medicare sources of revenue include the general tax base or a special tax. In Massachusetts, a bill (H. 1099) that calls for a similar trust fund was introduced in this session but is unlikely to pass.

Next to society as a whole, teaching hospitals — and their public mission of training, research and indigent care — are most at risk if GME funding is severely restricted. They are therefore trying to be more creative in supporting GME. Many are looking to private sources such as foundations or pharmaceutical, biomedical and biotechnological companies for academic research dollars.

New York State, which trains about 15 percent of the nation's residents, has begun a six year pilot program with approval from the Health Care Financing Administration (HCFA). This program aims to eliminate existing incentives that cause hospitals to maintain or expand their residency slots even when there is a probable oversupply of physicians and health service delivery is shifting to ambulatory settings. Participating institutions agree to reduce their residents by 20 to 25 percent over five years. To cushion the financial blow of lost Medicare GME payments, HCFA will provide funding that will maintain financing at current levels in the first year and gradually reduce payments over the next six. Over the long run, the program will save money for Medicare and, because of New York's position as the preeminent state for GME, will help reverse a growing oversupply of physicians.

HCFA recently opened this program to Massachusetts hospitals as well, but they have declined to participate, calling for a national program to address physician oversupply instead. Many teaching hospitals in the state have already begun to reduce the number of residencies on their own; participation in the HCFA pilot would be seen as an additional financial hardship.

Future Directions

Graduate medical education presents a set of complicated policy issues within an already complicated system of financing and delivering health care. To understand the issues more completely, further study of the costs and benefits of residency programs and their funding sources, as well as an understanding of physician supply needs across the state, would be beneficial. At the center of it all are the residents, who need to be trained with skills that will serve the public and thrive in the managed care environment. Policy makers should consider alternative sources and mechanisms of GME funding to replace the possible loss of federal funds, as well as how to link GME financing to physician workforce needs. Finally, GME reformers must look at the future of the Commonwealth's teaching hospitals which — in addition to being sites of valuable training, research, specialty and indigent care — are important engines of the economy.

Further Reading

1. *Journal of the American Medical Association*, Vol. 276, No.9 (September 4, 1996)º
2. *Statement of the Institute of Medicine on the Nation's Physician Workforce: Options for Balancing Supply and Requirements* before the Sub-Committee on Health, Committee on Ways and Means, US House of Representatives, April 16, 1996
3. The Bureau of National Affairs, *Health Care Policy Report*, Vol. 5, No. 8 (February 24, 1997)

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